MDR Tracking Number: M5-04-1989-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 4, 2004. According to the TWCC Rule 133.308 (e)(1), date of service 3/3/03 was received after the one year filing deadline, therefore is not eligible for review.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The office visits with manipulation, neuromuscular re-education, electrical stimulation, myofascial release, therapeutic exercises and mechanical traction rendered on 3/4/03 through 3/13/03 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 17, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	MAR	Paid	EOB Denial Code	Rationale
3/13/03	97112 97012 97250	$35.00 $25.00 $50.00	$35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note, supports delivery of service. Recommend reimbursement in the amount of $98.00
3/14/03	99213-MP 97112 97012 97250	$50.00 $35.00 $25.00 $50.00	$48.00 $35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note,

						supports delivery of service. Recommend reimbursement in the amount of $146.00

3/13/03 3/14/03 3/17/03 3/18/03 3/20/03 3/24/03 3/25/03 3/27/03	97110 x 3 units/ day	$135.00 $135.00 $135.00 $135.00 $135.00 $135.00 $135.00 $135.00	$105.00 $105.00 $105.00 $105.00 $105.00 $105.00 $105.00 $105.00	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	No EOB	Consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-on-one therapy. Reimbursement is not recommended.
3/17/03	99213-MP 97112 97012 97250	$50.00 $35.00 $25.00 $50.00	$48.00 $35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note, supports delivery of service. Recommend reimbursement in the amount of $146.00.
3/18/03	99213-MP 97112 97012 97250	$50.00 $35.00 $25.00 $50.00	$48.00 $35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note, supports delivery of service. Recommend reimbursement in the amount of $146.00.
3/20/03	99213-MP 97112 97012 97250	$50.00 $35.00 $25.00 $50.00	$48.00 $35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note, supports delivery of service. Recommend reimbursement in the amount of $146.00.
3/24/03	99213-MP 97112 97012 97250	$50.00 $35.00 $25.00 $50.00	$48.00 $35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note, supports delivery of service. Recommend reimbursement in the amount of $146.00.
3/25/03	99213-MP 97112 97012 97250	$50.00 $35.00 $25.00 $50.00	$48.00 $35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note, supports delivery of service. Recommend reimbursement in the amount of $146.00.

3/27/03	99213-MP 97112 97012 97250	$50.00 $35.00 $25.00 $50.00	$48.00 $35.00 $20.00 $43.00	$0.00	No EOB	Neither party submitted copies of EOBs, however, review of the reconsideration HCFA 1500s reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Review of the office visit note, supports delivery of service. Recommend reimbursement in the amount of $146.00.
The requestor is entitled to reimbursement in the amount of $1,067.00						

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 3/4/03 through 3/27/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

May 27, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1989-01
TWCC #:
Injured Employee:
Requestor:
Respondent:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ------. The patient reported that while at work he injured his back when the bulldozer he was driving hit a large hole, causing the patient to bounce up and down repeatedly. The diagnoses for this patient have included lumbar radiculitis, lumbar sprain/strain, thoracic and lumbar sprain/strain, and muscle spasm. The patient underwent an MRI of the lumbar spine that was reported to have shown a herniated disc at L4-L5. On 1/22/03, 2/5/03, and 2/19/03 the patient underwent lumbar epidural injections followed by physical therapy. The patient was evaluated by an orthopedic surgeon and was referred for an anterior lumbar interbody fusion that was performed on 4/2/03, followed by a posterolateral fusion at the L4-5, and L5-S1 levels. Postoperatively the patient was treated with active and passive therapy.

Requested Services

OV with manipulation, neuro reeducation, electrical stimulation, myofascial release, therapeutic exercises, and mechanical traction from 3/4/03 through 3/13/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter 4/26/04
2. Letter 12/12/02
3. P.T. notes 2/25/03 – 3/27/03
4. MRI report 12/30/02

Documents Submitted by Respondent:

1. No Documents Submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a male who sustained a work related injury on ------. The ------ chiropractor reviewer also noted that the diagnoses for this patient included lumbar radiculitis, lumbar sprain/strain, thoracic and lumbar sprain/strain, and muscle spasm. The ------ chiropractor reviewer further noted that the patient underwent an anterior lumbar interbody fusion on 4/2/03 that was followed by a posterolateral fusion at the L4-5 and L5-S1 levels. The ------ chiropractor reviewer explained that the patient was scheduled for a complex two-step surgical procedure. The ------ chiropractor reviewer indicated that the care this patient received before surgery was to relieve pain and increase stability. The ------ chiropractor reviewer explained that the better strength and conditioning the patient had going into surgery, the better the outcome. Therefore, the ------ chiropractor consultant concluded that the ov with manipulation, neuro reeducation, electrical stimulation, myofascial release, therapeutic exercises, and mechanical traction from 3/4/03 through 3/13/03 were medically necessary to treat this patient's condition.

Sincerely,
